The Basic Health Program: Findings from Maryland's Report

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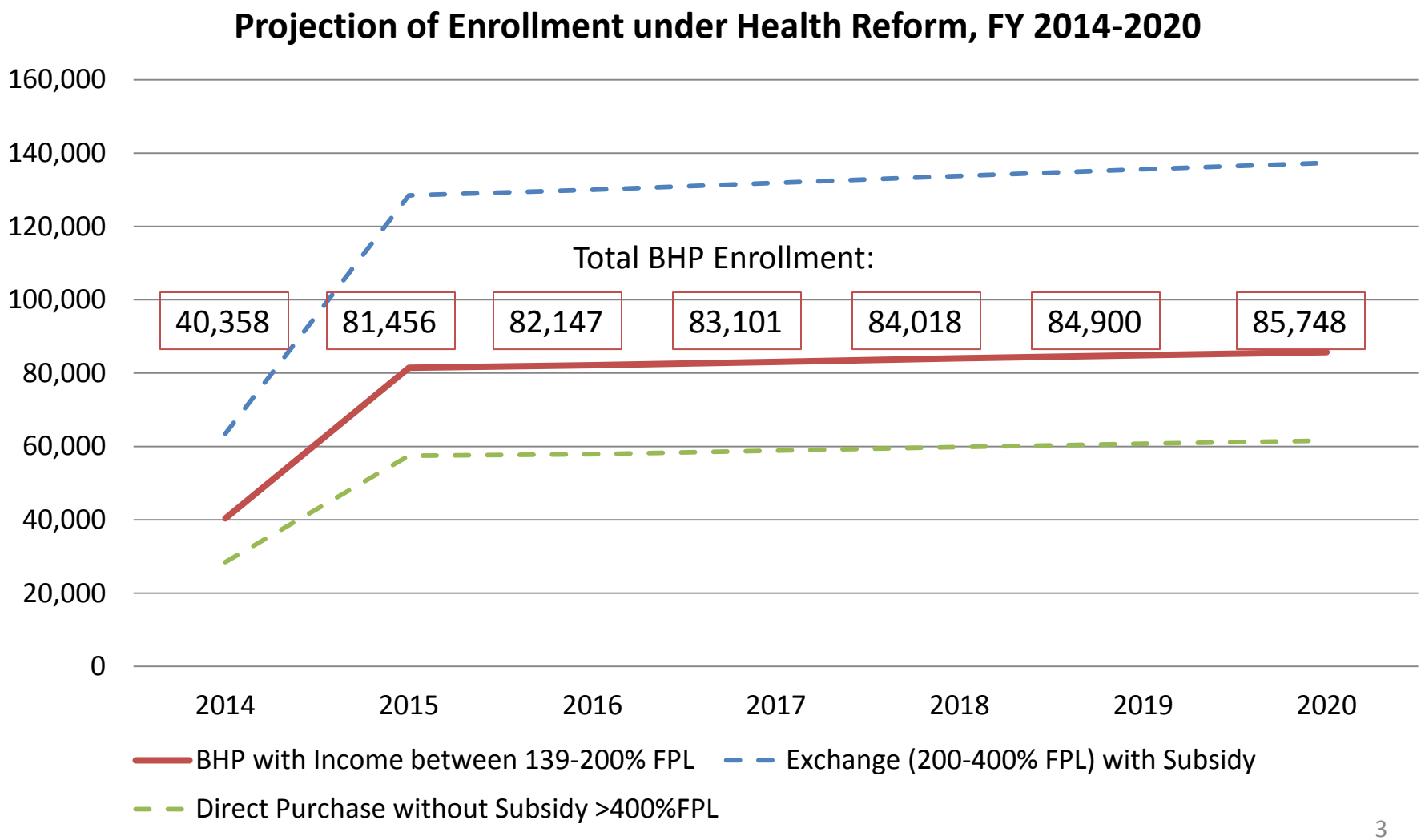
February 14, 2012

The Report: Findings

A variety of factors were studied to enable an objective decision by Maryland's policymakers:

- Potential Enrollment and the Effect on the Health Benefit Exchange
- Administrative Issues for DHMH, and the Financial Impact to the State
- Continuity, Provider Participation, and Churn

Using a take-up rate of 75-80%, the BHP is expected to enroll around 82,000 adults by FY 2016.



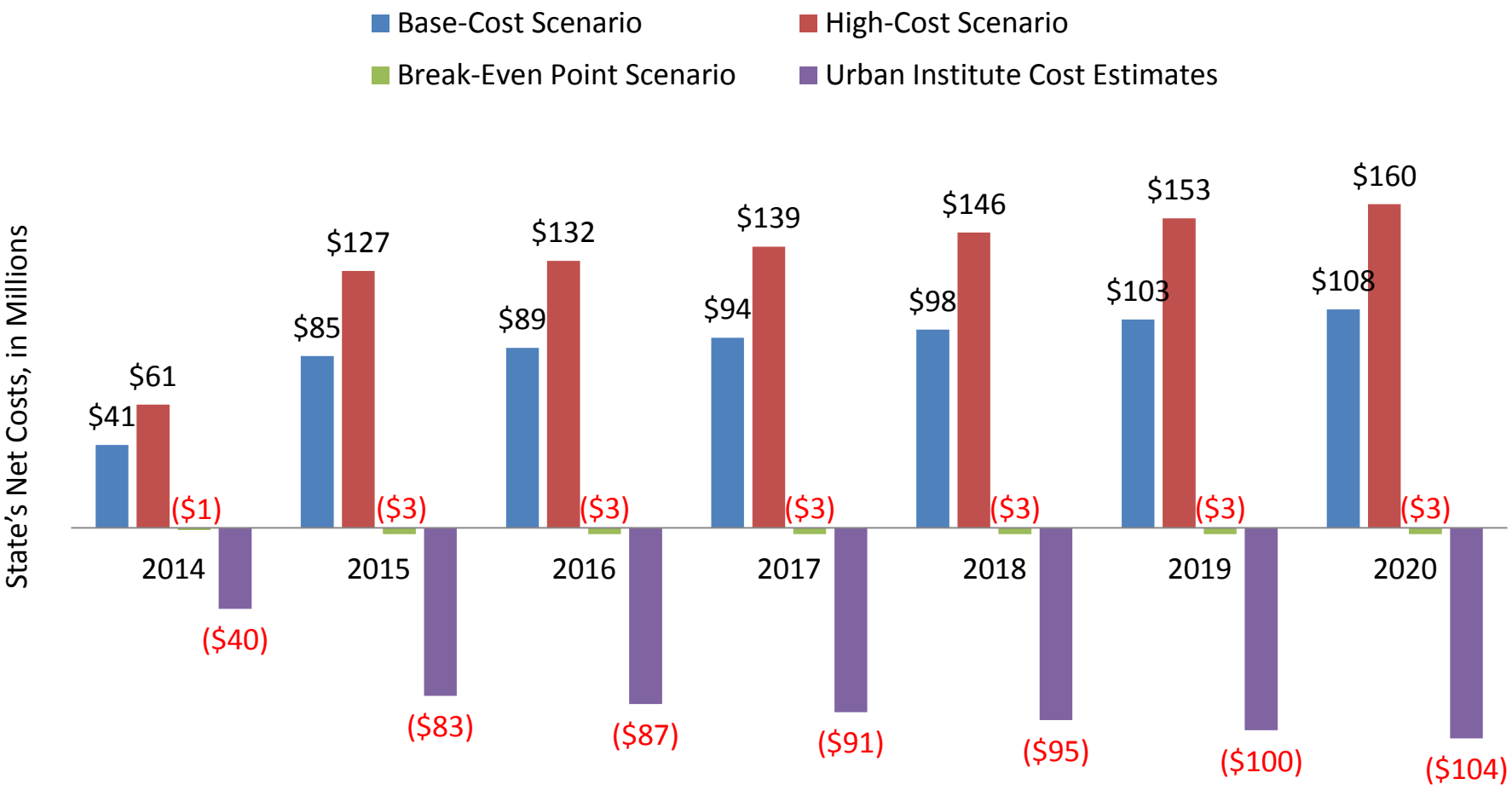
High enrollment in the BHP could divert funds away from the Exchange or create adverse selection.

- Reduces enrollment by a projected 82,000 by 2016
- Could reduce participation of carriers in the Exchange given the loss of volume
- Could reduce the Exchange's leverage in the insurance market, in the event the Exchange seeks to be an "active purchaser"
- Could essentially change risk pool in the Exchange
- Could hurt the self-sustainable of the Exchange's financing structure, should the Exchange be financed by enrollees or carrier volume in the Exchange

Administrative expenses and other operational issues at DHMH need to be considered when determining the viability of a BHP in Maryland.

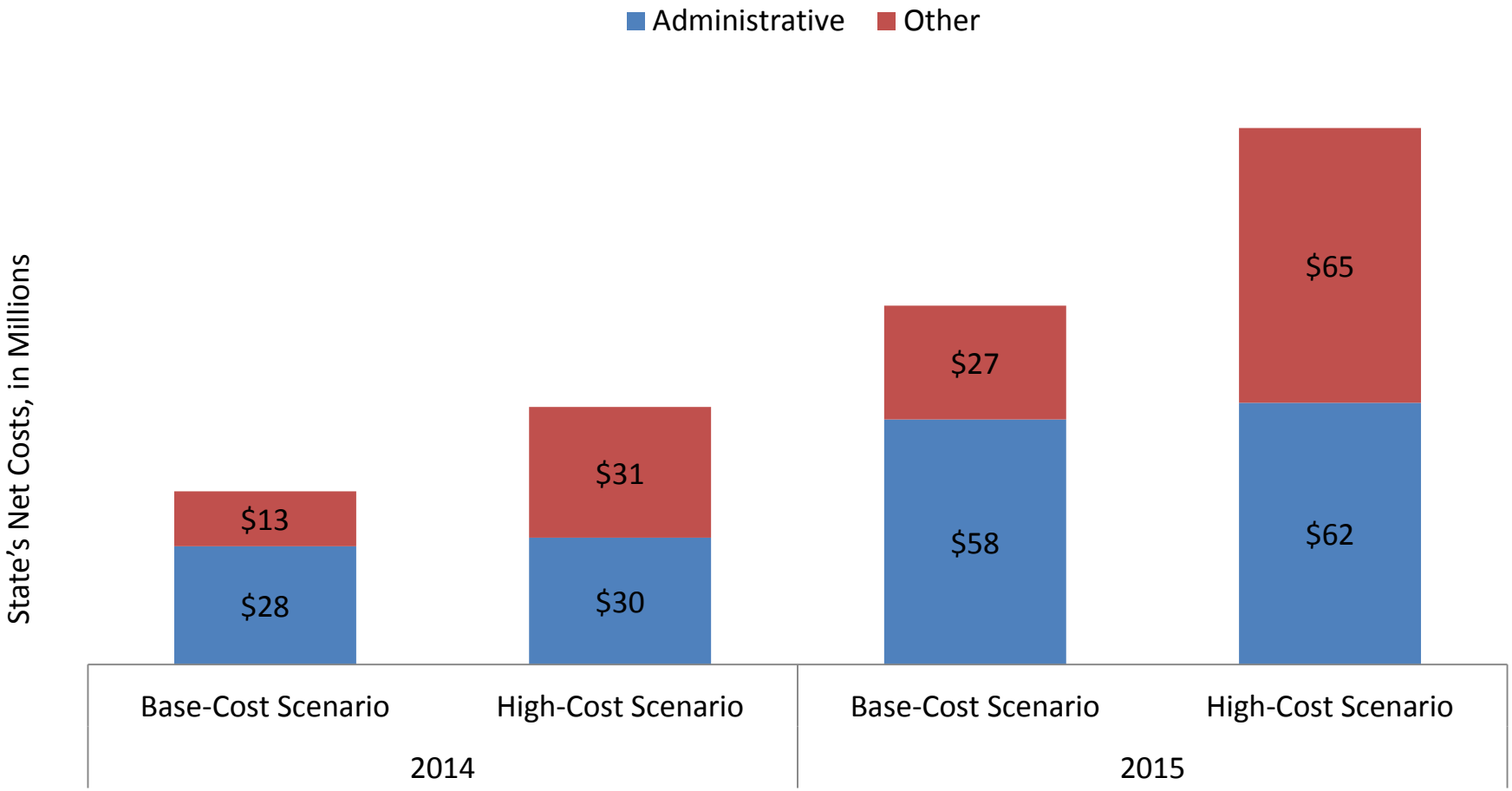
- Administrative burden and the use of BHP dollars
  - State will be responsible for program management and quality monitoring
  - Cost allocation for eligibility to be determined
- Premium collection
  - Medicaid current premium collection program handles about 16,000 enrollees a year; BHP estimates close to 81,500 by FY 2015
- Programming changes to MMIS

DHMH and Hilltop's scenarios all show a net cost to the State; the assumptions from the Urban Institute's 50-state report shows net savings (to be passed on to beneficiaries) of $40 million in 2014 . . .



Note: Cost estimates exclude 90-day payment delay.

…and it is still unknown whether or not savings can be used to cover administrative costs, which account for up to 68% of total state costs.



Note: Cost estimates exclude 90-day payment delay.

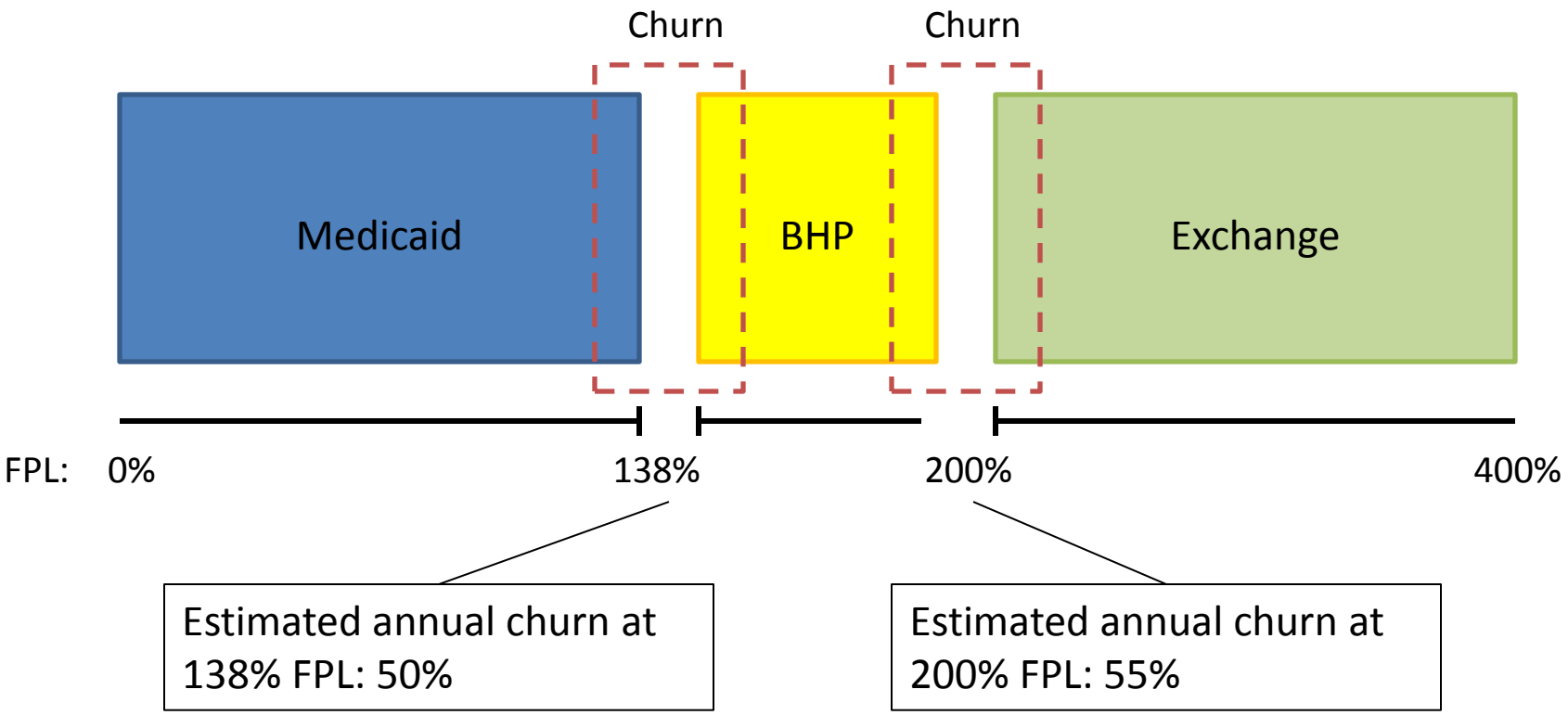
Financial Impact to the State

- In addition to the potential for paying BHP administrative costs with 100% state dollars, the State would be responsible for all medical costs over and above the federal contribution
- Based on Hilltop's analysis, premiums in the individual market would need to increase by 16-24% in 2014 to achieve breakeven in the BHP premiums to the MCOs

Continuity and Provider Participation

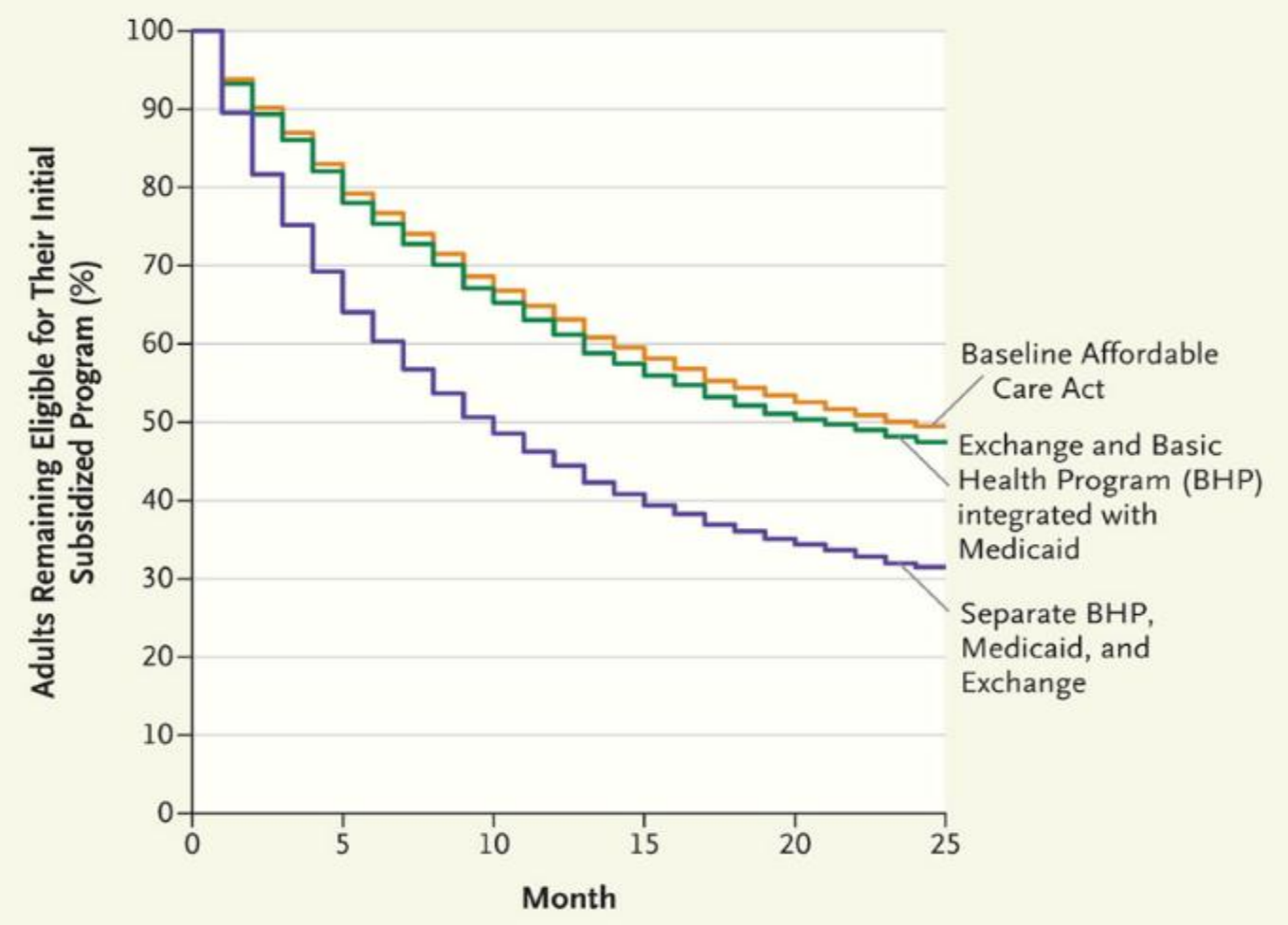
- Continuity is a major concern as individuals churn between Medicaid and the Exchange at 138% FPL
- Individuals would likely have same MCO in Medicaid and BHP if Maryland encouraged MCO participation in BHP
- Benefit packages may differ, depending on BHP savings or available state resources
- Depending on reimbursement rates, providers may limit the number of Medicaid/BHP patients they see

A BHP would not necessarily reduce churn; the rate of churn at 200% FPL is likely similar to the rate at 138%...



Note: Churn rates were estimated based on churn in the MCHP population; a study in the New England Journal of Medicine revealed similar findings.

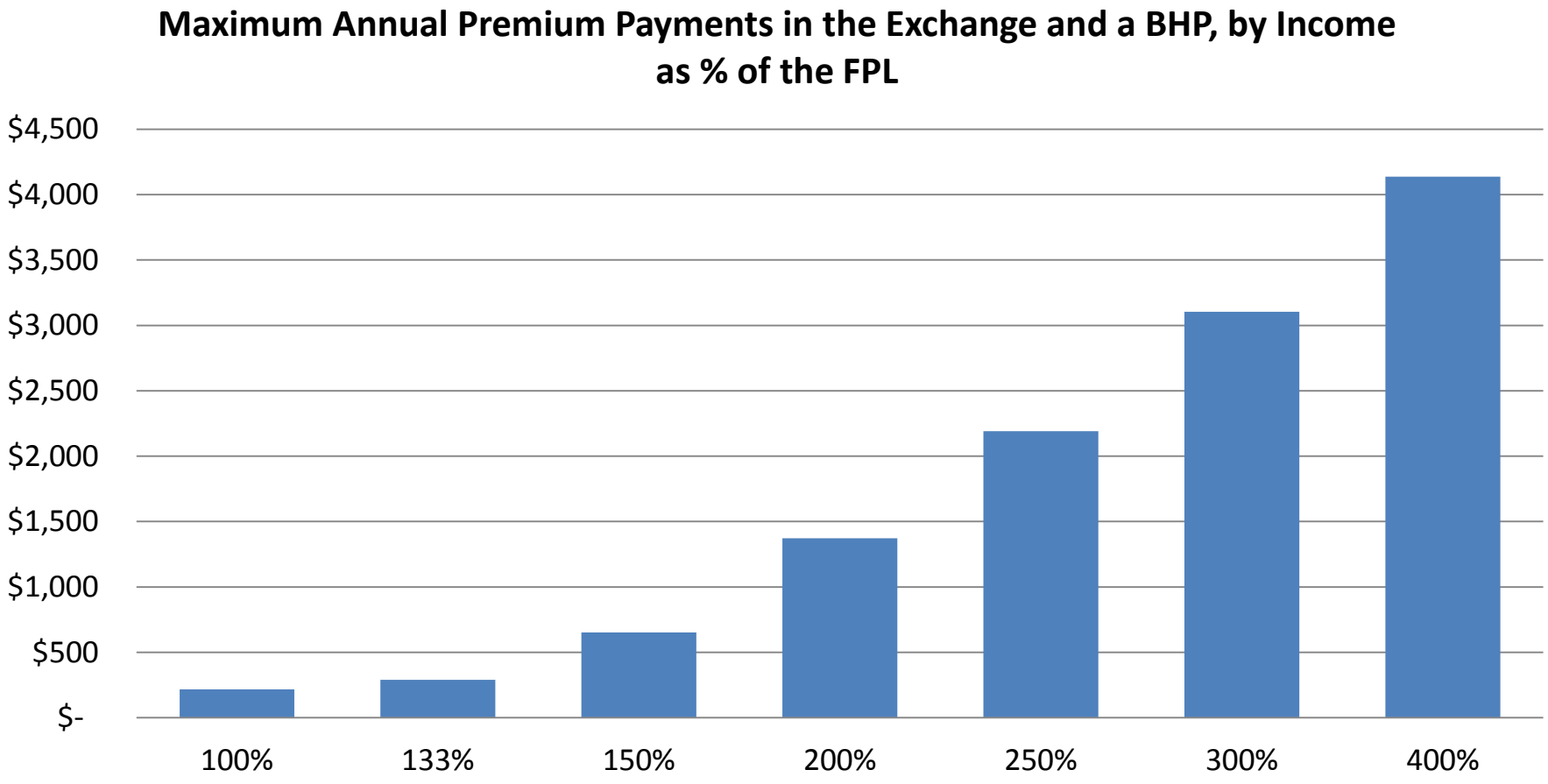
One study showed that, in states operating separate Medicaid, BHP, and Exchange programs, just 44% of individuals are likely to remain eligible for their initial program after one year.



This national study also found that, though churn was reduced at 138% FPL, there would be a more-than-offset increase in churn at 200% FPL, <u>resulting in more overall churn with a BHP</u>.

Source: Graves, J. A.; Curtis, R.; & Gruber, J. 2011. Balancing Coverage Affordability and Continuity under a Basic Health Program Option. N Engl J Med.

It is unknown how a BHP will affect consumer affordability, as this is heavily reliant on the cost of premiums in the individual market in 2014.



Consumer Affordability

- The ACA's sliding scale subsidies were designed to reduce the penalties for individuals who experience changes in income or family size
- A study in the New England Journal of Medicine explained that transitioning from a BHP to the Exchange would have larger implications the consumer than transitioning from Medicaid to the Exchange
  - E.g. A family moving from a BHP into the Exchange at 200% FPL could see the value of its benefits fall by as much as 25%

Source: Graves, J. A.; Curtis, R.; & Gruber, J. 2011. Balancing Coverage Affordability and Continuity under a Basic Health Program Option. N Engl J Med.

Recommendation

- Because of the large number of unknowns, and because there is no deadline for when a state must establish a BHP, Medicaid is recommending that Maryland delay a determination about the BHP until more federal guidance is released, and more information on rates and the state fiscal risks are available
- Conversations around this issue will continue at the next Health Care Reform Coordinating Council meeting (April)

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